

GEORGIA COMPOSITE BOARD OF
PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND
MARRIAGE AND FAMILY THERAPISTS

APPLICATION FOR CLINICAL SOCIAL WORKER
LICENSURE BY EXAMINATION,
EXAMINATION WAIVER OR
REINSTATEMENT
(LICENSE LAPSED GREATER THAN 12 MONTHS)



Cathy Cox
Secretary of State

Mollie Fleeman
Division Director



Secretary of State
Professional Licensing Boards Division
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-1300

Cathy Cox
SECRETARY OF STATE
www.sos.state.ga.us

Mollie L. Fleeman
DIVISION DIRECTOR
Professional Licensing Boards
478-207-1670**478-207-1676 Fax

Dear Master/Clinical Social Worker Applicant:

It is with great pleasure that we provide you with application information about MSW/CSW licensure requirements for practice in Georgia. If you have questions after careful review of the information, we invite you to give the office a call at 478-207-1670. Georgia is a wonderful state in which to live and work and we wish you great success as you make your career plans.

Because of the tremendous volume of applications received in our office, it takes approximately four to six weeks from the date the application is received by the Professional Licensing Boards for the applications specialist to review the contents of the application. In order to ensure fairness to all applicants involved, the applications are reviewed ***in the order received without exception.***

In addition, the Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists actually invests the time to *personally* review each application. The Board only meets one day each month and therefore, it is vital that you submit a **complete and accurate application along with all required supporting documents.**

Review and approval of applications is only one of the Board's responsibilities. The Board frequently has several licensees scheduled for personal appearances or the Board attorney for consultation and legal advice on complex issues. The Board also has as a frequent agenda item, the review and discussion of new or revised Board rules. Many times the Board is given a limited timeframe to accomplish work requested by other state agencies or the Secretary of State, as well as requests from many others. Please keep this in mind as you make personal commitments for testing dates, interviews, or work assignments. It is a good rule of thumb to allow two Board meetings for review of your documents. Give yourself plenty of time to ensure you receive Board approval for testing or licensure at the time you need it.

Please also keep in mind that all applications and supporting documents can be downloaded from the web site, www.sos.state.ga.us/plb/counselors. One click is all it takes and your consistent use of the web site for needed documents means the applications specialists will have more time for processing of applications for Board review. The law and rules of the Composite Board are also available at the web site. If you need access to a computer you have excellent resources in your public libraries and libraries associated with schools and universities, as well as commercial copying establishments. Board staff are also available for questions and assistance and can be reached at 478-207-1670.

Sincerely,

Lee H. Tracy
Executive Director
Health and Consumer Services

Georgia Composite BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
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www.sos.state.ga.us/plb/counselors

APPLICATION FOR CLINICAL SOCIAL WORKER LICENSURE

*** GENERAL INSTRUCTIONS ***

YOUR APPLICATION PACKET CONTAINS:

- General Instructions
- Application for Licensure
- Form A: Social Work Education Verification Form or Official Transcript
- Form B: Social Work Directed Experience Verification Form
- Form C: Social Work Supervision Verification Form
- Form D: Social Work Personal Reference Form
- Form E: Social Work Missing or Deceased Supervisor Affidavit
- Fee Schedule – **Application fees are non-refundable. Checks returned for insufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20.**
- Georgia Laws/Rules may be obtained at our website www.sos.state.ga.us/plb/counselors

COMPLETE APPLICATIONS:

- The Board reviews only complete applications with all required information and application materials received by the deadline date.
- **You are responsible for ensuring that your file is complete.** There are no exceptions!!
- The Board must have received all the supporting documents which you have listed or checked on your application that you are using to satisfy the licensure requirements, e.g., Education verification, directed clinical experience and supervision.
- List on the application only the name/s of the employer/s and supervisor/s who will submit documents in support of your application.
- A file which is not complete will be closed one year from the date the application was received in the Board office.

APPLICANT FILE:

- The Board staff will open your file as soon as the first document is received in this office.
- All licensure requirements should be met, except the passing of the examination, prior to submission of your application.
- You will be sent a deficiency letter if required documents have not been received.

APPLICATIONS REVIEW:

- The Social Work Standards Committee reviews applications and makes recommendations to the full Board.
- The Board generally meets only once a month to review applications.
- **IF YOUR APPLICATION IS APPROVED** — You will receive an official letter with the Board seal within 10 days following the meeting and instructions on how to schedule the Clinical or Advanced Examination for yourself with ASWB.
- **IF YOUR APPLICATION IS DENIED** — You will be sent a disapproval letter in which the reasons for the denial are stated and instructions for appealing to the Committee to request a reevaluation of your application and to meet with the Committee, if you wish.

COMPLETING FORMS

- Provide only requested information. If the Board requires additional information, you will be notified in writing. You may assume that if you are asked for something, it is really needed and the requirement may not be waived.
 - All forms must be typed or legibly printed, filled out completely and, when required, notarized.
- Use only the forms provided by the Board. If you photocopy a 2-sided form, do not copy it as 2 separate pages.

NAME/S: If some of your records are in different names, please notify the Board.

NAME OR ADDRESS CHANGES: It is the Applicant's responsibility to keep the Board notified whenever you change

your name or mailing address. Such notification must be in writing and you must reference the profession and the Board in your notice. A change of name request must be notarized and must state the reason for the change, i.e. marriage, divorce, etc., with a copy of relevant official documentation.

APPLICATION MATERIALS: Except for Form A-Social Work Education Verification Form which must be sent directly from the academic institution/s to the Board at the above address, all other forms, properly notarized and signed, should be included with your Application. Note that certain forms must be placed in a sealed envelope with the appropriate signature over the envelope flap and returned to you for inclusion with your application materials.

YOUR COPY: Keep a complete copy of your application materials, except those under seal.

MANNER OF LICENSURE: You must submit the entire application packet for consideration, which includes application, transcript, supervision and directed experience forms, two personal reference forms, and official scores from ASWB if you've already passed the examination.

EXAMINATION — You must meet licensure requirements, in order to qualify to take the examination.

EXAMINATION WAIVER — You must meet all licensure requirements, have taken and passed the Advanced or Clinical Examination through ASWB, and send your scores or have your scores sent from ASWB to the Board.

REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS) — You must meet the licensure requirements, and re-take the examination, if approved.

DISABILITY ACCOMMODATION — The Board will provide reasonable accommodation to a qualified applicant with a disability in accordance with the Americans with Disability Act (ADA). If you have a disability and may require accommodation, you must contact the Board office to obtain the *"Request for Disability Accommodation Guidelines."* The Board must receive all application materials, including the information requested in the Guidelines, by the application deadline.

VETERANS — If you have served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President, you may be eligible for Veterans' Preference Points to be added to your examination scores. Submit a copy of your DD 214 Form with your application.

EXAMINATION

- You may take either the Clinical or Advanced Examination, both of which are computerized tests.
- When you are approved by the Board to take the Examination, you will receive a letter.
- The Board will send notice to ASWB that you have been approved. You may then contact ASWB directly to schedule yourself to take the Examination on the date of our choice.
- You will be sent the ASWB *Candidate Handbook* which contains all the necessary information regarding the Examination.
- When the Board receives notification that you have passed the Examination, you will be issued a Clinical Social Work License.

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
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 237 Coliseum Drive, Macon, Georgia 31217-3858
 (478) 207-1670 (Telephone) * (478) 207-1676 (Fax)] www.sos.state.ga.us/plb/counselors

FEE SCHEDULE

APPLICATION FEE FOR LICENSURE BY EXAMINATION

| | |
|---|----------|
| ■ Licensed Professional Counselor [LPC] - \$100 APPLICATION - \$80 EXAMINATION FEE | \$180.00 |
| ■ Associate Licensed Professional Counselor [ALPC] - \$100 APPLICATION - \$80 EXAMINATION FEE | \$180.00 |
| ■ Licensed Master Social Worker [LMSW] - Application Fee | \$100.00 |
| ■ Clinical Social Worker [CSW] - Application Fee | \$100.00 |
| ■ Marriage and Family Therapist [MFT] -Application fee | \$100.00 |
| Upon approval by Board, make examination fee payable and mail to: "PES" | \$295.00 |
| ■ Associate Marriage and Family Therapist [AMFT] - Application fee | \$100.00 |
| Upon approval by Board, make examination fee payable and mail to: "PES" | \$295.00 |

APPLICATION FEE WHERE EXAMINATION HAS BEEN TAKEN AND PASSED [EXAMINATION WAIVER]

| | |
|---|----------|
| ■ This fee is for applicants who have passed the examination and will not re-take that examination [e.g., NBCC-Certified LPC and ALPC applicants, LAMFT applicants for MFT licensure, LMSW]. | \$100.00 |
|---|----------|

APPLICATION FEE FOR LICENSURE BY ENDORSEMENT

| | |
|---|----------|
| ■ This fee is for applicants who are licensed in other states who apply for Georgia licensure based upon that credential. (NOT APPLICABLE TO SOCIAL WORKERS) | \$100.00 |
|---|----------|

RE-EXAMINATION FEE

| | |
|--|----------|
| ■ Licensed Professional Counselor | \$ 80.00 |
| ■ Marriage and Family Therapist – paid directly to "PES" | \$295.00 |

BIENNIAL RENEWAL FEE

| | |
|---|----------|
| ■ 2 year license; expires September 30 of even years. | \$100.00 |
|---|----------|

LATE RENEWAL FEE

| | |
|--|----------|
| ■ Biennial renewal fee of \$100.00 and Surcharge of \$50.00 for late renewal between July 1 and December 31 of even year | \$150.00 |
|--|----------|

REINSTATEMENT FEE

| | |
|--|----------|
| | \$200.00 |
|--|----------|

APPLICATION FEE FOR INACTIVE STATUS

| | |
|--|------|
| | NONE |
|--|------|

APPLICATION FEE FOR RE-ACTIVATION OF LICENSE

| | |
|--|----------|
| | \$150.00 |
|--|----------|

DECORATIVE WALL CERTIFICATE FEE

| | |
|---|----------|
| ■ As of July 1, 2001, there will be an additional charge for a decorative Wall Certificate that is suitable for framing. Submit a separate cashier's check or money order made payable to the "Georgia Composite Board of PC, SW and MFT." | \$ 50.00 |
|---|----------|

LICENSURE VERIFICATION FEE

| | |
|--|----------|
| | \$ 25.00 |
|--|----------|

DUPLICATE BIENNIAL LICENSE CARD FEE

| | |
|---|----------|
| ■ For licensees who have lost, misplaced, or changed name since the issuance of the original biennial license | \$ 25.00 |
|---|----------|

MARRIAGE AND FAMILY THERAPY POST-GRADUATE COURSE APPROVAL APPLICATION

| | |
|--|----------|
| | \$100.00 |
|--|----------|

NOTE:

- Please make all checks or money orders payable to the "Georgia Composite Board of PC, SW and MFT," except as noted above for LMSW and CSW applications.
- **Application fees are non-refundable. Checks returned for insufficient funds will be assessed a \$30 service charge pursuant to O.C.G.A. § 16-9-20.**
- Examination fees are refundable. Any request for a refund must be submitted in writing.
- Checks returned for insufficient funds will be assessed a \$25 penalty in accordance with O.C.G.A. §16-9-20.

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**CLINICAL SOCIAL WORKER
APPLICATION FOR LICENSURE BY EXAMINATION,
EXAMINATION WAIVER AND
REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS)**

Please check box next to the license for which you are applying.

☐ **Licensure by Examination**

☐ **Licensure by Examination Waiver**

☐ **Licensure by Reinstatement (License Lapsed Greater Than 12 Months)**

- **You must submit the entire application packet for consideration – NO FAXED FORMS ACCEPTED**
■ **Attach Fee. Refer to Fee Schedule. Application fees are non-refundable.**

PART I - PERSONAL INFORMATION – ALL APPLICANTS

NAME: _____
Last First Middle Maiden

OTHER NAME USED, IF ANY _____

Legibly print your legal name (in order to be eligible to take the ASWB exam the name used on the license application must exactly match the name on the valid government issued I.D. used for identification for the ASWB exam).

HOME ADDRESS: _____
Street (P.O. Box not acceptable) City State ZIP Code

MAILING ADDRESS IF
DIFFERENT THAN STREET ADDRESS: _____
Street , P.O. Box City State Zip Code

BUSINESS ADDRESS: _____
Street City State Zip Code

✓ CHECK PREFERRED MAILING ADDRESS: ☐ Home ☐ Business

HOME PHONE: () _____ BUSINESS PHONE: () _____ FAX: () _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
Month/Day/Year [Optional: For identification, law enforcement, statistical
and administrative purposes]

PART II - PROFESSIONAL BACKGROUND – ALL APPLICANTS

PROFESSIONAL BACKGROUND: ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.

- ☐ Yes ☐ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?
- ☐ Yes ☐ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?
- ☐ Yes ☐ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?

- ☐ Yes ☐ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?
- ☐ Yes ☐ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?
- ☐ Yes ☐ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?
- ☐ Yes ☐ No 7. Have you ever been convicted of any criminal offense?
- ☐ Yes ☐ No 8. Have you ever been arrested, charged or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contendere or a plea entered pursuant to the provisions of the "Georgia First Offenders Act? You must respond, "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.
- ☐ Yes ☐ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?
- ☐ Yes ☐ No 10. Do you now hold or have you ever held a license as a social worker in any jurisdiction? If "yes" complete the following:
Jurisdiction _____ License No. _____
Date Issued _____ Expiration _____
- ☐ Yes ☐ No 11. Have you previously applied for the same license for which you are currently applying?
If "yes" name under which application was submitted: _____
- ☐ Yes ☐ No 12. Did you receive a Master's Degree in Social Work (MSW) from a Council on Social Work Education (CSWE) accredited school?
- ☐ Yes ☐ No 13. Did you complete a practicum or internship as part of your MSW Degree Program?
- ☐ Yes ☐ No 14. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

PART III - EXAMINATION WAIVER – ONLY APPLICANTS FOR WAIVER

EXAM TAKEN: I have taken and passed the ☐ Clinical **OR** ☐ Advanced Social Work Examination on _____.

COPY OF SCORE: ☐ I have requested that ASWB submit my score directly to the Board Office.

PART IV - SOCIAL WORK EXPERIENCE – EXAMINATION & EXAMINATION WAIVER APPLICANTS /
REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS)

INSTRUCTIONS:

- In answering Questions 3 - 7 below:
 - **Prior to 6/30/96** — One (1) year of Direct Experience = 800 hours in not less than 12 months or more than 36 months.
 - **After 7/1/96 - One** (1) year of Direct Experience = 1,000 hours in not less than 12 months or more than 36 months.
 - Supervision must have been by a qualified supervisor, as required by Board Rule Chapter 135-5-.03(3)(d) and verified on Form C - Supervisor Verification.]
-
- | | | |
|--|----|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. | Do you have an earned Master's Degree in Social Work (MSW) from a program in a school accredited by the Council on Social Work Education (CSWE) in which candidacy, conditional or accreditation status was in effect when the degree was awarded? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. | Did you complete a practicum or internship as part of your MSW Degree Program? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. | Do you have three (3) years of full-time experience in the practice of Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. | Do you have two (2) years of full time experience in the practice of Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. | Do you have a Doctoral Degree in: <input type="checkbox"/> Professional Counseling, <input type="checkbox"/> Social Work, <input type="checkbox"/> Marriage and Family Therapy, <input type="checkbox"/> Medicine, <input type="checkbox"/> Psychiatric Nursing, <input type="checkbox"/> Applied Psychology, <input type="checkbox"/> Pastoral Counseling or <input type="checkbox"/> Applied Child and Family Development which you want the Board to consider in lieu of the required years of supervised Clinical Social Work? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. | Do you have: <input type="checkbox"/> Thirty two (32) hours of supervision per year for years prior to 7/1/96 OR <input type="checkbox"/> Forty (40) hours of supervision after 7/1/96, as defined above as documented on Form C - Social Work Supervision Verification Form? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. | Have you obtained at least one (1) year of full time experience in the 36-month period prior to your Application? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. | Have you obtained eighteen (18) hours of Continuing Education during the last twelve (12) months that conforms to Board Rule Chapter 135-9-.01? |

PART V - DIRECTED EXPERIENCE – EXAMINATION & EXAMINATION WAIVER APPLICATIONS /
REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS)

INSTRUCTIONS:

- See below and check the appropriate section [1 - 4] for your Directed Experience and how you intend to show that you meet the requirements.
- List the name(s) of the Director(s) under whom you fulfilled the experience requirement for licensure and include the date(s) of employment.
- Have each Director complete a separate Form B — Professional Experience Verification Form to demonstrate that you meet the minimum experience requirement for licensure.
- See Board Rule Chapter 135-5-.04(5).

I obtained Directed Experience:

1. ☐ **Between July 1, 1987 and July 1, 1996** and am presenting evidence of:
- ☐ At least 800 hours of supervised experience within the two (2) years immediately preceding this Application **OR**
 - ☐ Having met the continuing education requirement during the year immediately preceding this Application [at least 2.5 hours ethics, 10 core hours and 5 related hours].
- AND Prior to July 1, 1996**, I am presenting evidence:
- ☐ Of having practiced Clinical Social Work for a minimum of 2400 hours of supervised Post-Master's Degree Social Work Experience over a period of no less than 36 months and no more than 108 months, the first 1600 hours of which were under supervision and direction in Clinical Social Work practice **AND**
 - ☐ That I also have 96 hours of supervision, 64 of which may be group supervision and 64 of which must have been provided by a licensed Clinical Social Worker.
2. ☐ **After July 1, 1996** — I am presenting evidence of:
- ☐ At least 1000 hours of supervised experience within two (2) years immediately preceding this Application **OR**
 - ☐ Having met the continuing education requirement during the year immediately preceding this Application [at least 2.5 hours ethics, 10 core hours and 5 related hours]. **AND**
 - ☐ Of having practiced Clinical Social Work for a minimum of 3000 hours post Social Work Master's Degree supervised experience acquired over a period of no less than 36 months or more than 108 months, the first 2000 hours of which were under supervision and direction in the practice of Clinical Social Work **AND**
 - ☐ Documentation of having acquired 120 hours of supervision during this time, no more than 50% of which was group supervision and at least 50% of which was provided by a licensed clinical social worker duly qualified as a supervisor. **OR**
 - ☐ I have shown hardship or good cause and ask the Board to extend the time to acquire supervision and/or experience.
3. ☐ **I hold a Master's Degree in Social Work AND a Doctoral Degree in:** Professional Counseling, Social Work, Marriage and Family Therapy, Medicine, Psychiatric Nursing, Applied Psychology, Pastoral Counseling or Applied Child and Family Development which degree program included a Supervised Clinical Internship and **wish to substitute this for one (1) year of supervision. AND**
- ☐ I have **experience prior to July 1, 1996** and:
 - ☐ I have presented evidence of two (2) years (1600) hours of Post-Master's Supervised Experience under direction in the practice of Clinical Social Work, obtained in no less than 24 months nor more than 72 months. **AND**
 - ☐ I have documented 64 hours of supervision (in addition to the clinical internship), 50% of which was supervised by a Social Worker, a maximum of 50% of which was group supervision.
 - ☐ I have **experience after July 1, 1996** and:
 - ☐ I have presented evidence of two (2) years full time supervised Post-Master's Degree Experience (2000 hours) under direction in the practice of Clinical Social Work obtained in no less than 24 months and no more than 72 months. **AND**
 - ☐ I have documented 80 hours of supervision by a duly qualified supervisor, 50% of which may be group supervision; 50% of which was provided by a licensed Clinical Social Worker. **OR**
 - ☐ I have shown hardship or good cause and ask the Board to extend the time to acquire supervision and/or experience.

NAME OF DIRECTOR:

DATES OF EMPLOYMENT:

FROM:

TO:

NAME OF DIRECTOR:

| | | |
|---|-------|------------------------------|
| DATES OF EMPLOYMENT: | FROM: | TO: |
| NAME OF DIRECTOR: | | |
| DATES OF EMPLOYMENT: | FROM: | TO: |
| PART VI –SUPERVISION – EXAMINATION & EXAMINATION WAIVER APPLICANTS / REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS) | | |
| <u>INSTRUCTIONS:</u> <ul style="list-style-type: none"> ■ List the name(s) of the Supervisor(s) under whom you fulfilled the experience requirement for licensure and include the date(s) of employment and check applicable period below. ■ Have each Supervisor complete a separate Form C — Professional Experience Supervision Verification Form to demonstrate that you meet the minimum experience requirement for licensure. ■ See Board Rule Chapter 135-5-.04(5) ■ Supervision prior to July 1, 1987 - Supervisor must either be a licensed Psychologist or Psychiatrist OR have an earned Master's Degree in Social Work from a CSWE-accredited program AND one (1) year of supervision means 32 hours of clinical supervision in no less than 12 months and no more than 36 months. ■ Supervision between July 1, 1987 and July 1, 1996 - Supervisor must be licensed as a Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist or a member of the Academy of Certified Social Workers. ■ Supervision after July 1, 1996 - Supervisor must be a licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist and have practiced in their specialty for at least 200 clock hours over a minimum of two (2) years after licensure AND one year means 40 hours of clinical supervision in no less than 12 months and no more than 36 months. | | |
| NAME OF SUPERVISOR: | | |
| DATES OF SUPERVISION | FROM: | TO: |
| NAME OF SUPERVISOR: | | |
| DATES OF SUPERVISION | FROM: | TO: |
| NAME OF SUPERVISOR: | | |
| DATES OF SUPERVISION | FROM: | TO: |
| PART VII – EDUCATION – EXAMINATION & EXAMINATION WAIVER APPLICANTS / REINSTATEMENT (LICENSE LAPSED GREATER THAN 12 MONTHS) | | |
| NAME OF COLLEGE/UNIVERSITY WHERE YOU OBTAINED YOUR MASTER'S IN SOCIAL WORK: | | |
| <input type="checkbox"/> I have completed and forwarded to my school Form A - Social Work Education Verification Form. | | |
| PART VIII – OATH – ALL APPLICANTS | | |
| I attest that to the best of my knowledge and belief the information provided above is true and accurate. I acknowledge that I may be required to furnish additional information promptly for this Application to be processed. | | |
| Date _____ Sworn to and subscribed before me this _____ day of _____, _____ | | Signature of Applicant _____ |
| Notary Public My Commission Expires _____ | | NOTARY SEAL |

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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSE BY EXAMINATION / REINSTATEMENT
(LICENSE LAPSED GREATER THAN 12 MONTHS)
SOCIAL WORK EDUCATION VERIFICATION FORM
FORM A

INSTRUCTIONS: NO FAXED FORMS ACCEPTED

- Please print or type.
- **APPLICANT** - Complete Part I and forward this form to the college or university from which you received your Master of Social Work Degree.
- **EDUCATIONAL INSTITUTION** - Complete Part II and return it to the Board at the above address.

PART I – APPLICANT

NAME ON FILE AT EDUCATIONAL INSTITUTION:

First Middle Last Maiden

CURRENT ADDRESS:

Street City State Zip Code

DATE OF GRADUATION:

PART II – EDUCATIONAL INSTITUTION

NAME:

LOCATION [City and State]:

DATES OF ATTENDANCE

FROM:

TO:

TOTAL # OF ACADEMIC YEARS:

DEGREE CONFERRED:

DATE CONFERRED:

PROGRAM NAME AND CURRICULUM DESCRIPTION:

DATES OF PRACTICUM/INTERNSHIP:

☐ Clinical

☐ Other

Date
Telephone #: () _____
Fax #: () _____

Signature of Attesting Official
Title: _____

SEAL OF COLLEGE/UNIVERSITY

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
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APPLICATION FOR CLINICAL SOCIAL WORKER LICENSE BY EXAMINATION / REINSTATEMENT
(LICENSE LAPSED GREATER THAN 12 MONTHS)

SOCIAL WORK DIRECTED EXPERIENCE VERIFICATION FORM
FORM B

INSTRUCTIONS: NO FAXED FORMS ACCEPTED

- Please print or type.
- **APPLICANT** – Complete Part I and forward this form to the agency or organization in which you completed your directed experience practicing Social Work.
- **AGENCY OR ORGANIZATION** - The Director must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.

PART I – APPLICANT

NAME OF APPLICANT:

First

Middle

Last

Maiden

SOCIAL SECURITY NUMBER:

PART II – AGENCY OR ORGANIZATION

INSTRUCTIONS:

- "Direction" means the on-going administrative oversight of an employer or superior of a practitioner's work.
- For experience obtained **before 6/30/96**, one year of Directed Experience means a minimum of 800 hours in the practice of Social Work during a 12-month period within two (2) years of the application.
- For experience **after 7/1/96**, one year of Directed Experience means a minimum of 1000 hours in the practice of Social Work for no less than a year during the 36 months preceding the application.

CERTIFICATION

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL PRACTICED SOCIAL WORK AT:

Name of Agency or Organization

Address: _____
Street City State Zip Code

From : _____ To: _____ For _____ Hours Per Week.

Date Signature of Director or Authorized Person

Name of Agency or Organization Printed Name

Title/Position

Street Address

City State Zip Code

Telephone: () Fax: ()

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS
AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive
Macon, Georgia 31217-3858
(478) 207-1670 (Telephone) * (478) 207-1676 (Fax)
www.sos.state.ga.us/plb/counselors

APPLICATION FOR CLINICAL SOCIAL WORK LICENSE BY EXAMINATION / REINSTATEMENT (LICENSE
LAPSED GREATER THAN 12 MONTHS)
SOCIAL WORK SUPERVISION VERIFICATION FORM
FORM C

INSTRUCTIONS: Please print or type. **NO FAXED FORMS ACCEPTED.**

APPLICANT

- **Complete Part I** and forward this form to each supervisor from the organization or agency in which you completed your directed experience practicing Social Work. Complete a separate form for each Directed Experience Supervisor listed in your application. Use this form to only verify Social Worker supervision.
- If you need additional forms, you may photocopy this form.

DIRECTED EXPERIENCE SUPERVISOR

- The Directed Experience Supervisor must Complete Part II and return it to the Applicant for inclusion with the Application for licensure.
- "Supervision" means the direct clinical review by a Supervisor for the purpose of training or teaching of a Social Worker's interaction with a client.

PART I - APPLICANT

NAME OF APPLICANT:

First Middle Last Maiden

SOCIAL SECURITY NUMBER:

PART II - DIRECTED EXPERIENCE SUPERVISOR

I HEREBY CERTIFY THAT I SUPERVISED THE ABOVE-NAMED INDIVIDUAL IN THE PRACTICE OF SOCIAL WORK AS FOLLOWS:

INDIVIDUAL SUPERVISION:

Total Hours: Hours Per Week: From: To:

GROUP SUPERVISION:

Total Hours: Hours Per Week: From: To:

DESCRIPTION OF PRACTICE SUPERVISED:

I attest that I served as this Applicant's Directed Experience Supervisor, as defined above, that this description is a true and accurate representation of my supervision of this Applicant, and I:

☐ Recommend ☐ Do Not Recommend this Applicant for licensure.

Date Signature of Directed Experience Supervisor

Years of Experience After License Issued: Printed Name:

Address: Street City State Zip Code

Telephone #: () Fax #: ()

License Type: License #: State: Date Issued: Exp. Date:

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- PART I - APPLICANT

PART II - REFERENCE

Address:

Other Phone: ()

Dates of Teaching/Supervisory Relationship: FROM: _____ TO: _____
Month/Day/Year Month/Day/Year

Title: _____
Agency/Institution: _____
Address: _____

ADDITIONAL COMMENTS:

[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

Signature of Reference

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CLINICAL SOCIAL WORKER
DIRECTED EXPERIENCE - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
FORM E

INSTRUCTIONS: NO FAXED FORMS ACCEPTED

■ Please type or print clearly.

The Directed Experience Supervisor must be:

PRIOR TO JULY 1, 1987 — A licensed Psychologist, Psychiatrist or have earned an MSW from a CSWE-accredited program.

JULY 1, 1987 - JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist, Psychiatrist or a member of the Academy of Certified Social Workers.

AFTER JULY 1, 1996 — A licensed Clinical Social Worker, Professional Counselor, Marriage and Family Therapist, Psychologist or Psychiatrist and has practiced in their specialty for at least 2000 clock hours over 2 years following licensure. See Board Rule Chapter 135-5-.04(5)(f) -(h).

APPLICANT:

- Make every effort to locate the as many of the supervisors of Directed Experience as necessary to document the required Directed Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, you have obtained sufficient directed experience to meet licensure requirements, but after a diligent search you are unable to locate enough Supervisors to document the required time, you may attest to undocumented Directed Experience by taking the Oath below.
- The Board may require additional information upon review.

PART I - APPLICANT

NAME: SOCIAL SECURITY NUMBER:

I obtained experience: ☐ Prior to July 1, 1987 ☐ July 1, 1987 - July 1, 1996 ☐ After July 1, 1996

PART II - OATH

Under penalty of perjury, as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate:

Name of Supervisor: _____
who served as my supervisor while I worked under the direction of: _____
at: _____ Name of Director

Name of Agency or Organization Address City State Zip

and that this supervisor has the following credentials:

License Type: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapist
☐ Psychologist ☐ Psychiatrist ☐ Member of the Academy of Certified Social Workers
☐ Earned an MSW from a CSWE-accredited program

License #: _____ State: _____ Date Issued: _____ Expir. Date: _____ Years of Practice After Licensed: _____

The supervision of my Social Work Practice was provided during the following 12-month period/s:

| | | | |
|------------------------|-------|-----|--------------|
| YEAR 1 OR PART THEREOF | FROM: | TO: | TOTAL HOURS: |
| YEAR 2 OR PART THEREOF | FROM: | TO: | TOTAL HOURS: |
| YEAR 3 OR PART THEREOF | FROM: | TO: | TOTAL HOURS: |
| YEAR 4 OR PART THEREOF | FROM: | TO: | TOTAL HOURS: |

Date _____ Signature of Applicant
Sworn to and subscribed before me this
_____ day of _____, _____.

Notary Public
My Commission Expires: _____

NOTARY SEAL

